

**U.S. Department of Labor**

Office of Administrative Law Judges  
50 Fremont Street - Suite 2100  
San Francisco, CA 94105

(415) 744-6577  
(415) 744-6569 (FAX)



**Issue Date: 29 May 2003**

Case No: 2000-BLA-00171

In the Matter of

DALE A. OLSON

Claimant,

v.

PEABODY COAL COMPANY  
Employer,

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS,  
Party-in-Interest.

**APPEARANCES<sup>1</sup>:**

Jonathan Wilderman, Esq.  
Denver, Colorado  
For the Claimant.

Scott A. White, Esq.  
St. Louis, Missouri  
For the Employer.

BEFORE: DONALD B. JARVIS  
Administrative Law Judge

**DECISION AND ORDER DENYING BENEFITS**

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder,

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<sup>1</sup>The Director, Office of Workers' Compensation Programs, was not represented at the hearing.

located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On November 19, 1999, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (Dir. Ex. 42)<sup>2</sup> A formal hearing on this matter was conducted on April 23, 2002, in Billings, Montana, by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and examine witnesses, to cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations. Director's Exhibits 1-42, Claimant's Exhibits 1-30, and Employer's Exhibits 1-11 and 14-20 were received into evidence. (Tr. 4, 17, 64) Employer's Exhibits 12 and 13, the depositions of Drs. Fino and Renn, were marked for identification but not admitted into evidence based on the Claimant's objections. (Tr. 62)

### **ISSUES**

The issues in this case are:

1. The length of the miner's coal mine employment;
2. Whether the miner has pneumoconiosis as defined by the Act and regulations;
3. Whether the miner's pneumoconiosis arose out of coal mine employment;
4. Whether the miner is totally disabled; and
5. Whether the miner's disability is due to pneumoconiosis.

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(Dir. Ex. 42)

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

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<sup>2</sup> In this Decision, "Dir. Ex." refers to the Director's Exhibits, "Emp. Ex.." refers to the Employer's Exhibits, "CL. Ex." refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

## **FINDINGS OF FACT**

### **Procedural History:**

Claimant, Dale A. Olson, filed an application for Black Lung benefits on January 8, 1998. (Dir. Ex. 1) A Department of Labor claims examiner denied benefits on March 17, 1998 for failure to establish total disability due to pneumoconiosis. (Dir. Ex. 18) On April 1, 1998, Claimant requested an informal conference. (Dir. Ex. 17) The Acting District Director held an informal conference and issued a Memorandum of Informal Conference on August 2, 1999, denying benefits. (Dir. Ex. 38) Mr. Olson requested a hearing before an administrative law judge on August 10, 1999. (Dir. Ex. 39) On November 19, 1999, the claim was transferred to the Office of Administrative Law Judges. (Dir. Ex. 42) The undersigned conducted a formal hearing on this matter on April 23, 2002, in Billings, Montana.

### **Background:**

Claimant was born on April 12, 1927, and was seventy-five years old at the time of the hearing. (Dir. Ex. 1, 7; Tr. 25) Claimant completed the eighth grade and married Phyllis Simonson on April 17, 1949. (Dir. Ex. 1, 7; Tr. 26) The couple has no dependent children.

Claimant alleged 32 1/4 years of coal mine employment, and the employer stipulated to 35½ years, ending on May 1, 1991, when he retired. (Dir. Ex. 1; Tr. 20-21) All of his work was above ground and exposed him to thick coal dust. (Tr. 28, 48) At the hearing, Ed Sopher, a co-worker since 1970, confirmed Mr. Olson's testimony regarding his coal mine employment. (Tr. 52-56) I accept the stipulation and find that the claimant has established 35½ years of coal mine employment.

Mr. Olson also testified that he began treating with Dr. Pueringer in January 1997 because of breathing difficulties. (Tr. 35) He is short of breath especially when climbing stairs. (Tr. 36) Mr. Olson has been on constant oxygen for the last two years. (Tr. 36-37) He feels he could not return to his last coal mining job as a shovel operator because of his breathing trouble. (Tr. 39) That job required climbing up and down fifteen feet to the get to the cab several times a day, sometimes lifting heavy parts, and cleaning the tracks.

The Claimant testified that he underwent an angioplasty to open two coronary arteries in March 1998 and has had no further trouble since. (Tr. 42) He stated that he takes no medication for a heart condition. Mr. Olson confirmed that he smoked one pack of cigarettes a day for 23 years before quitting in 1970 and taking up smokeless tobacco. (Tr. 43)

Mrs. Olson also testified at the hearing. She noticed that the Claimant first developed a cough and then shortness of breath to the point that he had to rest even on short walks. (Tr. 57) She stated that other than showering and dressing himself, he spends most of the day in a chair. His activity level has extremely diminished over the past several years. (Tr. 58) She has observed that his breathing improves somewhat when he takes prednisone. (Tr. 59)

### **MEDICAL EVIDENCE**

#### **Chest X-rays:**

<b>X-ray Date</b>	<b>Exhibit Number</b>	<b>Physician</b>	<b>Qualifications</b>	<b>Reading</b>
1-7-1997	Dir. Ex. 30	Dr. Binns	“B” reader, <sup>3</sup> BCR <sup>4</sup>	½; s/t; 4 zones
	Dir. Ex. 16	Dr. James	“B” reader	3/2; s/t; 6 zones
	Dir. Ex. 17	Dr. Irion		Fine bilateral interstitial infiltrates, possibly representing viral pneumonitis
	Dir. Ex. 24	Dr. Spitz	“B” reader, BCR	2/2; s/t; 4 zones but no evidence of coal workers’ pneumoconiosis; may be asbestosis or idiopathic pulmonary fibrosis or a collagen vascular disease

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<sup>3</sup> A “B” reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. Physicians’ qualifications are a matter of public record at the HHS National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.51) Consequently, greater weight is given to a diagnosis by a “B” Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

<sup>4</sup> Board-certified in radiology.

Dir. Ex. 24	Dr. Wiot	“B” reader, BCR	Negative for coal workers’ pneumoconiosis but a very abnormal x-ray that could be idiopathic pulmonary fibrosis
Dir. Ex. 25	Dr. Shipley	“B” reader, BCR	2/2; t/s; 4 zones but not consistent with coal workers’ pneumoconiosis; suggestive of relatively advanced interstitial pulmonary fibrosis
Dir. Ex. 28	Dr. Wheeler	“B” reader, BCR	No evidence of silicosis or coal workers’ pneumoconiosis; usual interstitial pneumonitis or possible collagen vascular disease such as scleroderma
Emp. Ex. 7	Dr. Renn	“B” reader	2/2; t/u; 4 zones; pleural thickening in the interlobar fissure

	Emp. Ex. 9	Dr. Fino	“B” reader	Negative for coal workers’ pneumoconiosis; diffuse, bilateral interstitial fibrosis in two middle and two lower zones
1-21-1997	Dir. Ex. 14	Dr. James	“B” reader	3/2; s/t
	Dir. Ex. 15	Dr. Irion		Fine bilateral interstitial infiltrates and/or pulmonary fibrosis
	Dir. Ex. 24	Dr. Spitz	“B” reader, BCR	2/2; s/t; 4 zones but no evidence of coal workers’ pneumoconiosis; may be asbestosis or idiopathic pulmonary fibrosis or a collagen vascular disease
	Dir. Ex. 24	Dr. Wiot	“B” reader, BCR	Negative for coal workers’ pneumoconiosis but a very abnormal x-ray that could be idiopathic pulmonary fibrosis

Dir. Ex. 25	Dr. Shipley	“B” reader, BCR	2/2; t/s; 4 zones but not consistent with coal workers’ pneumoconiosis; suggestive of relatively advanced interstitial pulmonary fibrosis
Dir. Ex. 28	Dr. Wheeler	“B” reader, BCR	No evidence of silicosis or coal workers’ pneumoconiosis; usual interstitial pneumonitis or possible collagen vascular disease such as scleroderma
Emp. Ex. 9	Dr. Fino	“B” reader	Negative for coal workers’ pneumoconiosis; diffuse, bilateral interstitial fibrosis in two middle and two lower zones
Emp. Ex. 8	Dr. Renn	“B” reader	2/2; t/u; 4 zones; pleural thickening in the interlobar fissure
Dir. Ex. 30	Dr. Binns	“B” reader, BCR	½; s/t; 4 zones

2-7-1997	Dir. Ex. 26	Dr. Bruschwein		Diffuse bilateral interstitial infiltrates which may represent interstitial fibrosis, although pneumonitis cannot be excluded
3-27-1997	Dir. Ex. 26	Dr. Pinkerton		Bilateral primarily basilar reticulonodular infiltrates
9-16-1997	Dir. Ex. 26	Dr. Herbert		Reticular interstitial markings bilaterally, consistent with fibrosis
1-29-1998	Dir. Ex. 11	Dr. Lereger <sup>5</sup>	“B” reader, BCR	2/2; t/s; 3 zones
	Dir. Ex. 22	Dr. Wiot	“B” reader, BCR	No evidence of coal workers’ pneumoconiosis although a very abnormal x-ray. Etiology of the process is unknown
	Dir. Ex. 23	Dr. Shipley	“B” reader, BCR	2/2; t/s; 4 zones, not consistent with coal workers’ pneumoconiosis; moderately severe interstitial fibrosis

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<sup>5</sup>This physician’s name is illegible but the handwriting looks like “Lereger.”



Dir. Ex. 24	Dr. Spitz	“B” reader, BCR	2/2; q/t; 3 zones but no evidence of coal workers’ pneumoconiosis; consistent with asbestosis; could be idiopathic pulmonary fibrosis
Dir. Ex. 12	Unreadable		2/2; t/t; 4 zones
Dir. Ex. 13	Dr. Gregory		Findings consistent with pneumoconiosis
Dir. Ex. 30	Dr. Binns	“B” reader, BCR	1/1; s/t; 4 zones
Dir. Ex. 28	Dr. Wheeler	“B” reader, BCR	No evidence of silicosis or coal workers’ pneumoconiosis; usual interstitial pneumonitis or possible collagen vascular disease such as scleroderma
Emp. Ex. 9	Dr. Fino	“B” reader	Negative for coal workers’ pneumoconiosis; diffuse, bilateral interstitial fibrosis in two middle and two lower zones
Emp. Ex. 3	Dr. Renn	“B” reader	2/2; t/u; 4 zones; pleural thickening in the interlobar fissure

2-24-1998	Dir. Ex. 26	Dr. Bruschwein		Pulmonary hyperinflation due to COPD <sup>6</sup> ; diffuse interstitial fibrosis
8-13-1998	Dir. Ex. 37	Dr. Wheeler	“B” reader, BCR	Negative for pneumoconiosis; moderate emphysema; usual interstitial pneumonitis
	Dir. Ex. 36	Dr. Shipley	“B” reader, BCR	No findings consistent with pneumoconiosis; pleural plaques and interstitial pulmonary fibrosis consistent with asbestos exposure
	Dir. Ex. 34	Dr. Wiot	“B” reader, BCR	Negative for coal workers’ pneumoconiosis but significant interstitial fibrosis which may be idiopathic pulmonary fibrosis or asbestosis
	Dir. Ex. 35	Dr. Spitz	“B” reader, BCR	No evidence of pneumoconiosis; may be consistent with asbestosis; findings possibly due to some other specific cause of pulmonary fibrosis or could represent idiopathic pulmonary fibrosis

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<sup>6</sup>Chronic obstructive pulmonary disease.

	Emp. Ex. 9	Dr. Fino	“B” reader	Negative for coal workers’ pneumoconiosis; diffuse, bilateral interstitial fibrosis in two middle and two lower zones
	Emp. Ex. 3	Dr. Renn	“B” reader	3/2; t/u; 4 zones; pleural thickening in the interlobar fissure
11-23-1999	Cl. Ex. 20	Dr. Mitchell		Extensive interstitial coarsening about bases and periphery of lungs most likely due to fibrosis
1-11-2000	Cl. Ex. 20	Dr. Mitchell		Fibrotic changes in bases and periphery of both lungs
5-7-2001	Cl. Ex. 20	Dr. Mitchell		Extensive interstitial fibrotic changes bilaterally in bases a little worse than 1/11/00 and clearly worse than 11/23/99
2-20-2002	Emp. Ex. 21	Dr. Repsher	“B” reader	3/3; t/s; 4 zones; coalescence of small pneumoconiotic opacities; honeycomb lung; pleural thickening in the interlobar fissure; cor pulmonale not consistent with asbestotic pneumoconiosis but are most likely UIP

Emp. Ex. 22	Dr. Wiot	“B” reader, BCR	3/3; t/s; 5 zones; co-alescence of small pneumoconiotic opacities; honeycomb lung; pleural thickening in the interlobar fissure; cor pulmon- ale; not coal workers’ pneumoconiosis
Emp. Ex. 23	Dr. Spitz	“B” reader, BCR	Negative for coal workers’ pneumoco- niosis; interstitial fi- brosis consistent with asbestosis; pleural thickening in the interlobar fissure; hon- eycomb lung
Cl. Ex. 20	Dr. Herbert		No change since 8/2/01; increased in- terstitial lung capaci- ties bilaterally consis- tent with interstitial pulmonary fibrosis
Cl. Ex. 20	Dr. Lehnherr		No change since 5/7/01; increased in- terstitial markings
Cl. Ex. 23, 24	Dr. Alexander	“B” reader, BCR	2/2; q/p; 4 zones

CT Scan Evidence:

A CT scan was taken on January 30, 1997 and interpreted by Dr. Wheeler, who is a “B” reader and a board-certified radiologist, on November 7, 1998. (Dir. Ex. 37) He found no evidence of pneumoconiosis. He felt that the peripheral interstitial fibrosis he detected was unlikely to be asbestosis because the benign asbestos-related pleural plaques are relatively small. Dr. Shipley interpreted the scan as revealing no findings consistent with coal workers’ pneumoco- niosis; pleural plaques consistent with asbestos exposure; and interstitial pulmonary fibrosis that is at least moderate in severity and consistent with, but not limited to, parenchymal asbesto-

sis. (Dir. Ex. 33) Dr. Spitz interpreted the scan on September 30, 1998, and found no evidence of coal workers' pneumoconiosis. (Dir. Ex. 32) He felt the findings of pleural plaques suggested previous asbestos exposure and added that the severe interstitial fibrosis would be consistent with asbestosis. Finally, he added that idiopathic pulmonary fibrosis must also be considered because the findings were very severe. Dr. Wiot read the scan on September 23, 1998, and opined that the findings were not those of coal workers' pneumoconiosis. (Dir. Ex. 29) He found pleural plaques and interstitial fibrosis. He felt asbestosis would be the prime consideration but that idiopathic pulmonary fibrosis would also have to be considered. Dr. Fino reviewed the CT scan on December 28, 2000 and opined that it revealed significant interstitial fibrosis but not coal workers' pneumoconiosis. (Emp. Ex. 11)

Pulmonary Function Tests:

<b>Date</b>	<b>Ex. No.</b>	<b>Age/ Height</b>	<b>FEV<sub>1</sub><sup>7</sup></b>	<b>FVC<sup>8</sup></b>	<b>MVV<sup>9</sup></b>	<b>Qualifies</b>
1-29-1997 Mild restriction	Dir. Ex. 26	69/71"	2.64	3.47	—	No
1-21-1997 Good effort and cooperation	Dir. Ex. 26	69/68.9"	2.99	4.21	—	No
1-31-1997	Cl. Ex. 22	69/68.9"	2.99	4.21	—	No
3-27-1997 Good effort and cooperation	Dir. Ex. 26	69/68.9"	3.26	4.48	—	No
7-16-1997 Good effort and cooperation	Dir. Ex. 26	70/68.9"	3.03	4.25	—	No
1-29-1998 Good effort and cooperation	Dir. Ex. 8	70/68 3/4"	4.06	5.96	127.8	No

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<sup>7</sup> Forced expiratory volume in one second.

<sup>8</sup> Forced vital capacity.

<sup>9</sup> Maximum voluntary ventilation.

8-13-1998	Dir. Ex. 26	71/69.5"	3.14	4.58	—	No
Good effort and cooperation						
11-23-1999	Cl. Ex. 22	72/69.7"	2.89	3.93	—	No
1-11-2000	Cl. Ex. 22	72/69.7"	2.98	4.07	—	No
2-28-2000	Cl. Ex. 22	72/69.7"	2.93	4.06	—	No
4-19-2000	Cl. Ex. 22	73/69.7"	2.76	3.85	—	No
7-11-2000	Cl. Ex. 22	73/69.7"	2.67	3.81	—	No
5-6-2001	Cl. Ex. 22	74/71"	2.53	3.67	—	No
6-20-2001	Cl. Ex. 22	74/70.9"	2.75	4.07	—	No
8-2-2001	Cl. Ex. 22	74/70.9"	2.37	3.53	—	No
—/9/2001	Cl. Ex. 22	74/70.9"	2.38	3.56	—	No
2-20-2002	Cl. Ex. 22	74/71"	2.34	3.40	—	No

Arterial Blood Gas Studies:

Test Date	Exhibit Number	pCO <sub>2</sub>	pO <sub>2</sub>	Qualifies	At Rest/ After Exercise
1-29-1998	Dir. Ex. 10	35.9	71.3	No	At rest
		33.2	74.6	No	After exercise
8-13-1998	Dir. Ex. 26	37.0	69.7	No	At rest
10-9-2001	Cl. Ex. 19	37	70	No	At rest
2-20-2002	Cl. Ex. 18	35	43	Yes	At rest

### Biopsy Evidence

Mr. Olson underwent a transbronchial biopsy of the lung and a bronchoalveolar lavage on February 7, 1997. (Dir. Ex. 26; Cl. Ex. 20, 21) Dr. Dennis Schreffler completed the surgical pathology report, providing both microscopic and gross descriptions. He diagnosed interstitial lung disease, fibrosis with anthracotic pigment deposition, and lymphocytic inflammation with prominent crush artefact. Dr. Richard L. Naeye provided a letter dated October 16, 1998, stating that the tissue in the bronchial biopsy had only a few very tiny fragments of black pigment at a site that revealed nothing of which might or might not be present in the lungs. (Dir. Ex. 33) He felt it was inappropriate as a pathologist to make interpretations based on clinical findings alone. Dr. Naeye, who is board certified in anatomic and clinical pathology, reviewed the biopsy evidence on March 23, 2002. (Emp. Ex. 14) He opined that the tissue from the bronchial biopsy contained no lung tissue from which the diagnosis of coal workers' pneumoconiosis could be made or excluded. Therefore, in his opinion, the biopsy evidence was insufficient to be the basis of the diagnosis of or elimination of the disease. Dr. Tuteur reviewed the reports of Drs. Naeye and Schreffler on April 1, 2002. (Emp. Ex. 15) He noted that the only tissue available for review was that of the bronchial biopsy, not the transbronchial lung biopsy as indicated by Dr. Naeye. He concluded that the tissue was not of the location that would allow evaluation for the presence or absence of coal workers' pneumoconiosis.

### Medical Opinions:

The record includes progress reports from Robert J. Pueringer of the Billings Clinic, dated January 31, 1997. (Dir. Ex. 26) Dr. Pueringer examined Mr. Olson, noting his medical history, complaints, 40 years of coal mine employment, and late inspiratory rales clinically. He also considered the results of a CT scan, an x-ray, and a pulmonary function study. Dr. Pueringer diagnosed severe interstitial lung disease secondary to idiopathic pulmonary fibrosis, chronic infection, bronchiolitis obliterans with organizing pneumonitis, connective tissue disease, and potential occult hypersensitivity pneumonitis. On March 27, 1997, April 17, 1997, July 16, 1997, September 16, 1997, February 24, 1998, Dr. Pueringer again assessed idiopathic pulmonary fibrosis and diffuse interstitial lung disease probably due to a viral infection.

Further progress reports from Dr. Pueringer are found in the record. (Cl. Exs. 1-16) They document follow-up visits from November 5, 1998 to February 20, 2002. The records verify a prescription for colchicine and show diagnoses of interstitial lung disease, upper airway congestion, a marked drop in diffusion capacity in November 1999, the set up of home oxygen in January 2000, the improvement of diffusing capacity after six weeks of prednisone treatment, and Dr. Pueringer's belief that the lung disease was acting like idiopathic pulmonary fibrosis. Dr. Pueringer noted on June 20, 2001 that Mr. Olson's pulmonary fibrosis responded to steroid therapy. A note on October 9, 2002 reveals that Mr. Olson informed Dr. Pueringer that he had worked around some asbestos, and Dr. Pueringer felt this may be the cause of the idiopathic pulmonary fibrosis.

Dr. Pueringer provided a letter dated March 25, 2002 in which he provided his credentials as a board certified internist and pulmonologist. (Cl. Ex. 26) He reiterated that he had considered 33 years of coal mine employment, the miner's status as a former smoker, a medical history, symptomatology, and the results of a pulmonary function study and physical examination. While he has treated the miner since 1997 for what he presumes is idiopathic pulmonary fibrosis, he also opined that Mr. Olson is fully disabled from any type of work due to both his cigarette smoking and coal dust exposure, which he feels contributed to the miner's disease. However, Dr. Pueringer also stated that "it is unclear whether his exposure to the co[al] dust was a significant contributor" of the idiopathic pulmonary fibrosis. He went on: "Noteworthy, it [coal dust] is known to cause emphysema, as well as coal worker[s'] pneumoconiosis. Though this is distinct from it, there is no question that dust burdens, particularly organic, can impair idiopathic pulmonary fibrosis, if that is truly what it is."

Dr. John Guicheteau examined the Claimant on February 10, 1998. (Dir. Ex. 9) He considered a medical history, symptoms and complaints, a history of smoking one pack of cigarettes a day for 23 years before quitting in 1970 and then taking up smokeless tobacco for an additional ten years, 18 years of coal mine employment, an x-ray, a pulmonary function study, a blood gas study, and a physical examination which revealed crackles in the left base. He diagnosed pneumoconiosis based on the x-ray, mining history, and lung biopsy, and arteriosclerotic cardiovascular disease. Dr. Guicheteau opined that he needed to differentiate between ischemic fatigue and pulmonary fatigue as the cause of Mr. Olson's disability. He did not specify how disabled he found the miner but added that both the pneumoconiosis and heart disease contributed to any impairment.

Dr. Lawrence Repsher examined Mr. Olson on August 13, 1998. (Dir. Ex. 26) He considered about 40 years of coal mine employment, a history of smoking one pack of cigarettes a day for over 23 years and chewing tobacco for ten years before quitting in the 1980s, symptoms, a medical history, an x-ray, a pulmonary function study, a blood gas study, and a physical examination that revealed normal breath sounds but bilateral inspiratory basilar rales. He also reviewed various medical records. Dr. Repsher found no evidence of coal workers' pneumoconiosis based upon the x-ray evidence, the pulmonary function study evidence (there was no evidence of either restrictive or obstructive disease), and the biopsy evidence. He diagnosed U.I.P., pointing out that severe isolated reduction in diffusing capacity and the biopsy evidence of giant cell and lymphocytic variant are consistent with U.I.P. Dr. Repsher stated that U.I.P. is of unknown cause and is not associated with coal mine dust exposure. Dr. Repsher is board certified in internal medicine and pulmonary disease.

Dr. Repsher provided answers to questions posed by the Deputy Director of the Black Lung Program in Denver Colorado, in a letter dated September 18, 1998. (Dir. Ex. 27) He explained that idiopathic pulmonary fibrosis refers to interstitial lung disease of unknown cause. U.I.P. stands for usual interstitial pneumonitis and is one of the IPF diseases. He explained that the diseases have been investigated epidemiologically and have not been shown to be related to



any specific occupational exposure since they appear in people of all ages and backgrounds. They are thought to be due to autoimmunity. Dr. Repsher further explained that an x-ray reading of 3/2; t/q does not medically mean the patient has pneumoconiosis because the reading may be consistent with many other pulmonary diseases. In considering Mr. Olson's entire clinical picture and the lung biopsy (which was definitive as to the cause of his interstitial lung disease), he concluded there was no evidence of coal workers' pneumoconiosis. Based on blood gas studies, Dr. Repsher opined that the miner is totally disabled but not due to pneumoconiosis. He attributed the disability to the non-occupational illness of UIP.

Dr. Repsher testified at the hearing. He provided his credentials and reiterated his examination findings. He explained that UIP (usual interstitial pneumonia) is also known as IPF (idiopathic pulmonary fibrosis). He acknowledged that Mr. Olson's coal mine dust exposure was sufficient to develop pneumoconiosis in a sensitive individual. (Tr. 69-70) Dr. Repsher reviewed the pulmonary function studies, concluding that he had normal spirometry initially but then developed a seriously abnormal diffusing capacity, which, according to Dr. Repsher, is not seen in simple coal workers' pneumoconiosis but is typical in UIP/IPF and can also be due to smoking. (Tr. 72) He testified that the bronchoalveolar lavage showed a mixture of giant cells and lymphocytes typical of UIP/IPF but not seen in pneumoconiosis and reiterated that the biopsy did not retrieve any lung tissue. (Tr. 73) Dr. Repsher explained that the colchicine and prednisone Mr. Olson takes treat UIP/IPF, but are ineffective toward coal workers' pneumoconiosis. (Tr. 74) Other factors leading to the diagnosis of UIP/IPF are the CT scan, the x-ray evidence, and the positive ANA test. (Tr. 77) Dr. Repsher attributed Mr. Olson's total disability entirely to UIP/IPF. (Tr. 78)

Dr. Peter G. Tuteur reviewed the medical evidence on June 19, 2000. (Emp. Ex. 1) He considered an unspecified coal mine employment history, a history of smoking for about thirty years, a medical history, 31 x-ray readings, three blood gas studies, seven pulmonary function studies, and the reports and records of Drs. Guicheteau and Repsher and the Billings Clinic. He found no evidence of pneumoconiosis but diagnosed diffuse interstitial process not consistent with coal workers' pneumoconiosis. He further diagnosed arteriosclerotic heart disease that was relieved by angioplasty. He found no significant impairment of pulmonary function, particularly no impairment arising out of coal mine employment. Finally, Dr. Tuteur, who is board certified in internal medicine and pulmonary disease, opined that Mr. Olson is totally and permanently disabled from working but that the disability is not due to coal workers' pneumoconiosis or coal dust exposure.

Dr. Tuteur, who is board certified in internal medicine and pulmonary disease, reviewed medical evidence on April 1, 2002. (Emp. Ex. 15) He considered 35 years of coal mine employment above ground, a history of smoking cigarettes for thirty years before switching to smokeless tobacco for the next fifteen years, the outpatient records from Dr. Pueringer, the pathology reports of Drs. Schreffler and Naeye, ten pulmonary function studies, and five x-rays reports. Dr. Tuteur diagnosed an interstitial pulmonary process. He noted that the only tissue

available for review was that of the bronchial biopsy, not the transbronchial lung biopsy as indicated by Dr. Naeye. He concluded that the tissue was not of the location that would allow evaluation for the presence or absence of coal workers' pneumoconiosis. Dr. Tuteur opined that Mr. Olson does not have clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis. He believes the miner is totally disabled but that the disability is not attributable even in part to coal mine dust inhalation or pneumoconiosis.

Dr. Tuteur was deposed on April 9, 2002, at which time he provided his credentials and reiterated his opinion that the miner does not have coal workers' pneumoconiosis. (Emp. Ex. 19) He believes the claimant has an interstitial pulmonary process unrelated to the inhalation of coal mine dust. He otherwise repeated his prior opinions.

On June 30, 2000, Dr. Abdulkadar Dahhan, who is board certified in internal medicine and pulmonary disease, reviewed the medical evidence (Emp. Ex. 4) He considered 40 years of coal mine employment, mainly on a dragline, the reports of Drs. Tuteur, Guicheteau, Pueringer, Zirpoli, and Repsher, the lung biopsy report, seven x-ray reports, three pulmonary function studies, and three blood gas studies. Dr. Dahhan diagnosed interstitial fibrosis and pulmonary fibrosis. He found no coal mine dust-induced lung disease. Dr. Dahhan opined that Mr. Olson's respiratory condition that developed in November 1996 was due to an event of unknown etiology and was not caused by, related to, or contributed to, his coal mine work or the inhalation of coal dust. He cited the biopsy evidence as proof of his conclusions because it showed no anthracotic or silicotic nodules. Other factors leading to his finding were the miner's response to immunosuppressive therapy, namely prednisone and colchicine, which would not be effective against a coal dust-induced disease. Dr. Dahhan opined that Mr. Olson is unable to return to his previous coal mine employment due to his age and coronary artery disease.

Dr. Joseph J. Renn, III reviewed the medical evidence on July 4, 2000. (Emp. Ex. 3) He considered about 23 years of coal mine employment as a strip miner and dragline operator, a medical history, a history of smoking one pack of cigarettes a day for 23-30 years before quitting sometime between 1970 and 1977, an EKG, eight x-rays, eight blood gas studies, six pulmonary function studies, the office records of Dr. Pueringer, the pathology report, and the reports of Drs. Repsher and Naeye. Dr. Renn diagnosed lymphocytic usual interstitial pneumonitis; benign asbestos-induced pleural plaques; minimal pulmonary emphysema; and arteriosclerotic vascular disease. He averred that Mr. Olson's conditions were neither caused by nor contributed to his exposure to coal mine dust. In his opinion, the emphysema resulted from years of smoking. Dr. Renn opined that the miner's ventilatory studies were not normal but that from a respiratory standpoint, he was not totally disabled. Dr. Renn felt, however, that when considering the whole man, Mr. Olson is totally disabled.

Dr. Renn was deposed on April 11, 2001, at which time he provided his credentials as being board certified in internal medicine and pulmonary disease. (Emp. Ex. 20) Dr. Renn

opined that the miner's arteriosclerotic coronary vascular disease was treated with angioplasty and was caused by smoking and age. He reiterated his opinion that Mr. Olson does not have a totally disabling pulmonary or respiratory impairment aggravated by, related to, or caused by his coal mining work. Dr. Renn believes that the claimant would be as disabled even if he had never worked in the mines.

Dr. Gregory J. Fino, who is board certified in internal medicine and pulmonary disease, reviewed the medical evidence on August 28, 2000. (Emp. Ex. 9) He considered 42 years of coal mine employment, mainly as a dragline operator, but lastly as a loading shovel operator, a medical history, a history of smoking one pack of cigarettes a day for 28 years, nine x-rays, six pulmonary function studies, two blood gas studies, the lung biopsy report, and the reports and records of Drs. Pueringer, Zirpoli, Naeye, and Repsher. Dr. Fino found the classic history and presentation of idiopathic interstitial pulmonary fibrosis, which he described as a disease of the general population and unrelated to coal mine dust inhalation. He explained that Mr. Olson's pulmonary fibrosis is not coal workers' pneumoconiosis. Dr. Fino opined that Mr. Olson is disabled from a respiratory standpoint from the idiopathic pulmonary fibrosis, but it was neither caused by nor contributed to by the inhalation of coal mine dust.

Dr. Fino reviewed additional evidence on April 2, 2002, namely the lung biopsy report and additional pulmonary function studies, blood gas studies, and x-ray reports. (Emp. Ex. 17) The additional evidence did not cause him to change his opinions.

## **DISCUSSION**

### **Applicable Law:**

The claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, claimant must establish, by a preponderance of the evidence, that he is totally disabled due to pneumoconiosis arising out of coal mine employment. See §§ 719.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

### **Pneumoconiosis:**

Since claimant's current application was filed after March 31, 1980, this claim will be considered under the provisions of Part 718. In establishing entitlement to benefits, claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a

preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations at § 718.201:

(a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical,” pneumoconiosis and statutory, or “legal,” pneumoconiosis.

(1) Clinical Pneumoconiosis. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico- tuberculosis, arising out of coal mine employment.

(2) “Legal Pneumoconiosis. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Section 718.201.

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

In this case, there are forty-seven readings of twelve separate x-rays. The first x-ray, dated January 7, 1997, was found positive by Drs. James and Renn, “B” readers, and by Dr. Binns, who is both a “B” reader and a board-certified radiologist. Dr. Irion did not diagnose

pneumoconiosis. Dr. Irion appears to have no particular qualifications for x-ray interpretation. Drs. Spitz and Shipley found category two disease but further explained that they did not find the film consistent with coal workers' pneumoconiosis. Rather, they felt the x-ray revealed idiopathic pulmonary fibrosis. Drs. Wiot, Wheeler, and Fino concluded that the film was negative for coal workers' pneumoconiosis, not assigning a value on the ILO-UICC classification system, but diagnosed either idiopathic pulmonary fibrosis or usual interstitial pneumonitis or interstitial fibrosis. Dr. Fino is a "B" reader, while Drs. Spitz, Shipley, Wiot, and Wheeler are dually certified readers. While the Benefits Review Board has held that it is proper for the administrative law judge to consider a physician's x-ray interpretation as positive for pneumoconiosis without considering his comments, *Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999), I would not consider my analysis sufficiently thorough unless I reviewed the entire reading of each physician, including comments. Therefore, on his x-ray, I consider there to be three positive readings for coal workers' pneumoconiosis, one that does not properly address its existence, and five negative readings. Of the five dually certified readers, whose interpretations are entitled to the greatest weight, *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984), four felt the x-rays did not reveal coal workers' pneumoconiosis. I defer to their readings and consider this x-ray negative for coal workers' pneumoconiosis. *Edmiston v. F&R Coal Co.*, 14 BLR 1-65 (1990).

The January 21, 1997 x-ray was found positive by Dr. James and Dr. Binns. Dr. Irion did not specify whether pneumoconiosis was present but did find interstitial infiltrates and/or pulmonary fibrosis. Drs. Spitz and Shipley found category two disease but again specified that there was no evidence of coal workers' pneumoconiosis. They found idiopathic pulmonary fibrosis/interstitial pulmonary fibrosis. Drs. Wiot, Wheeler, and Fino did not make a classification on the ILO-UICC scale but again asserted that coal workers' pneumoconiosis was not present. They suggested the diagnoses of idiopathic pulmonary fibrosis, usual interstitial pneumonitis, and interstitial fibrosis. In comparing the credentials of these physicians, Dr. James and Dr. Fino are "B" readers while Drs. Binns, Spitz, Shipley, Wiot, and Wheeler are dually certified. I consider only Dr. James's and Dr. Binns's readings as positive for coal workers' pneumoconiosis. Deferring to readers with superior qualifications, I am once again persuaded by the more widely shared opinion of Drs. Spitz, Shipley, Wiot, and Wheeler, and, thus, consider this x-ray negative for the disease.

The February 7, 1997 x-ray was interpreted by Dr. Bruschwein, whose credentials do not appear of record. He did not diagnose pneumoconiosis but suggested that the x-ray showed interstitial fibrosis. This opinion is consonant with those of better qualified readers of earlier and later films. As no other reader interpreted this x-ray, I consider it negative for coal workers' pneumoconiosis.

The March 27, 1997 x-ray was read by a Dr. Pinkerton as revealing reticulonodular infiltrates. He did not diagnose pneumoconiosis, and there are no other readings of the film in the record. Accordingly, I do not consider it positive for pneumoconiosis.

The August 16, 1997 x-ray was read by Dr. Herbert as consistent with fibrosis. He did not diagnose coal workers' pneumoconiosis. Once again, no other interpreter read this film. Thus, I consider it negative for pneumoconiosis.

The January 29, 1998 x-ray was read by ten different readers. Two physicians whose names are not legible found category two disease. (Dir. Exs. 11, 12) The former is both a "B" reader and a board-certified radiologist. Dr. Renn, a "B" reader, also found category two pneumoconiosis. Dr. Gregory, who has no particular qualifications for x-ray interpretation, found the film consistent with pneumoconiosis. Dr. Binns, a dually qualified reader, found category one pneumoconiosis. Drs. Shipley and Spitz noted category two disease but commented that the film was not consistent with coal workers' pneumoconiosis. Dr. Shipley suggested interstitial fibrosis while Dr. Spitz felt it showed asbestosis or idiopathic pulmonary fibrosis. Drs. Wiot, Wheeler, and Fino did not make a classification on the ILO-UICC scale but again asserted that coal workers' pneumoconiosis was not present. Dr. Wheeler suggested the diagnoses of usual interstitial pneumonitis or scleroderma, and Dr. Fino believed the film showed interstitial fibrosis. Thus, the positive readings come from the two physicians whose names are illegible, Dr. Gregory, Dr. Binns, and Dr. Renn. Of these doctors, two are dually certified. The negative readings are from Drs. Wiot, Shipley, Spitz, Wheeler, and Fino. All but Dr. Fino are dually certified. I consider the readings of Drs. Wiot, Shipley, Spitz, and Wheeler to be more thorough because they did not merely mark the boxes on the x-ray form. Consequently, I consider this x-ray negative for coal workers' pneumoconiosis.

The February 24, 1998 x-ray was read by Dr. Bruschwein only. He diagnosed diffuse interstitial fibrosis and chronic obstructive pulmonary disease but did not mention coal workers' pneumoconiosis. Therefore, I find this x-ray negative.

The August 13, 1998 x-ray was read by six physicians. Only one made a positive reading—Dr. Renn, a "B" reader. Dr. Fino, a "B" reader, and Drs. Wheeler, Shipley, Wiot, and Spitz, all dually certified, found the x-ray negative for coal workers' pneumoconiosis. Instead they made the same diagnoses listed above. I defer to the readings by the best qualified interpreters and consider this x-ray negative for coal workers' pneumoconiosis.

The November 23, 1999, January 11, 2000, and May 7, 2001 x-rays were each read once by Dr. Mitchell and no one else. Dr. Mitchell's credentials are not of record. He found fibrotic changes but did not diagnose coal workers' pneumoconiosis. Accordingly, I do not consider these x-rays positive for coal workers' pneumoconiosis.

The final x-ray was taken on February 20, 2002. Dr. Alexander, a dually certified reader, felt it showed category two pneumoconiosis. Dr. Repsher, a "B" reader, found category three pneumoconiosis even though he expressed his opinion that the changes were most consistent with usual interstitial pneumonitis. Dr. Wiot also noted category three disease but specified that

it was not coal workers' pneumoconiosis. Dr. Spitz found the film negative for pneumoconiosis. He believed it showed asbestosis. Drs. Herbert and Lehnher also did not find pneumoconiosis. Dr. Herbert suspected interstitial pulmonary fibrosis. A review of these readings shows that only Dr. Alexander felt the x-ray was positive for coal workers' pneumoconiosis. Dr. Repsher questioned his own finding and Dr. Wiot clarified that he did not diagnose coal workers' pneumoconiosis. Of the three dually qualified readers, a majority opined that the film was negative. I defer to their opinions and consider this final x-ray negative for coal workers' pneumoconiosis.

Based on the above analysis, with deference to the majority of the best qualified readers and their more thorough explanations for the miner's x-ray findings, I find that the x-ray evidence does not support a finding of coal workers' pneumoconiosis pursuant to § 718.201(a)(a). *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. A biopsy was conducted on February 7, 1997. Dr. Schreffler found anthracotic pigment deposition, but this finding alone is not equivalent to coal workers' pneumoconiosis. Drs. Naeye and Tuteur felt the biopsy failed to produce sufficient, adequate, or proper tissue to make or discredit the diagnosis of pneumoconiosis. Accordingly, I find that the biopsy evidence of record fails to establish the existence of coal workers' pneumoconiosis.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

This section requires a weighing of all relevant medical evidence to ascertain whether or not claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Only Dr. Guicheteau diagnosed coal workers' pneumoconiosis, while Drs. Repsher, Tuteur, Dahhan, Renn, and Fino did not. Dr. Pueringer clearly diagnosed interstitial lung disease secondary to idiopathic pulmonary fibrosis. He questioned whether coal dust exposure significantly contributed to this disease. He also stated that Mr. Olson's disease was distinct from "it," which I take to mean emphysema and coal workers' pneumoconiosis. Thus, despite Dr. Pueringer's later stating that coal dust probably contributed to his disease, I do not consider his opinion as equivalent to the diagnosis to coal workers' pneumoconiosis. Several factors affect the weight I place on these opinions.

I place less weight on Dr. Guicheteau's opinion because it is based largely on an x-ray and the biopsy evidence. The x-ray on which he relied is unclear, but because I have found the x-ray evidence to be negative for pneumoconiosis overall, his reliance on same weakens his opinion. More importantly, the biopsy evidence clearly does not support the findings of pneumoconiosis. Because two of the bases of his opinion are called into question, I discount it.

Dr. Pueringer is the miner's treating physician and I find that he has treated him frequently since 1997, primarily for pulmonary conditions, and has conducted necessary testing so as to obtain superior information of the miner's condition. § 718.104(d). Dr. Pueringer's opinion is supported by the overall x-ray evidence, the CT evidence, the biopsy evidence, and his own clinical findings. Accordingly, I give Dr. Pueringer's opinion controlling weight. § 718.104(d)(5).

The opinions of Drs. Repsher, Tuteur, Dahhan, Renn, and Fino support Dr. Pueringer's opinion. They, like Dr. Pueringer, maintain superior credentials, entitling their opinions to greater weight. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Their opinions are also well documented and reasoned based on the x-ray evidence, CT scan, biopsy evidence, and physical findings. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). These physicians had the opportunity to base their conclusions upon a thorough review of the medical data of record, thereby providing them with a broad base from which to draw their findings. Each physician also cogently explained how Mr. Olson's response to steroid therapy ruled out coal workers' pneumoconiosis and supported a diagnosis of idiopathic pulmonary fibrosis. Furthermore, the readings of the CT scan also support their findings. Accordingly, I place considerable weight on their opinions.



In relying on the well-reasoned explanations and reports of Drs. Pueringer, Repsher, Tuteur, Dahhan, Renn, and Fino, I find that Mr. Olson has failed to establish the existence of coal workers' pneumoconiosis pursuant to § 718.201(a)(4). Consideration of all the evidence under § 718.201 leads to the same conclusion.

Arising out of Coal Mine Employment:

In order to be eligible for benefits under the Act, claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that claimant has established 35 ½ years of coal mine employment, and as no rebuttal evidence was presented, I find that if the claimant had established the existence of pneumoconiosis, he would be entitled to the rebuttable presumption set forth at § 718.203(b), that it arose out of his coal mine employment.

Total Disability:

Claimant must establish that he is totally disabled within the meaning of the Act. Total disability is defined as Claimant's inability, due to pneumoconiosis, to perform his usual coal mine work or to engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(ii). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is insufficient x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, Claimant shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987). Furthermore, Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV<sub>1</sub> values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC values or MVV values equal to or less than the applicable table values. Alternatively, a qualifying FEV<sub>1</sub> reading together with an FEV<sub>1</sub>/FVC ratio of 55% or less may be sufficient to prove a totally disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2)(i) and Appendix B.

Included in the record are seventeen pulmonary function studies. Claimant's height was recorded, in inches, as 71, 68.9, 68.9, 68.9, 68.9, 68.75, 69.5, 69.7, 69.7, 69.7, 69.7, 69.7, 71, 70.9, 70.9, 70.9, and 71. I must resolve this height discrepancy. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). In this case, I choose to take the average height—69.88 inches. None of the studies yielded qualifying results. Accordingly, claimant has not proven total disability under § 718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of  $p\text{CO}_2$  to  $p\text{O}_2$ , which indicates the presence of a totally disabling impairment in the transfer of oxygen from the claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. There are four arterial blood gas studies of record. The first three, taken between January 1998 and October 2001, failed to produce qualifying values. The most recent study, however, taken February 20, 2002, yielded qualifying values. Because the most recent study shows a marked decrease in the  $p\text{O}_2$  value from even four months earlier, and corresponds with clinical records of Mr. Olson's breathing difficulty, I find it to be the most probative of the four tests. Therefore, I conclude that the blood gas study evidence tends to establish total disability under § 718.204(b)(2)(ii).

The total disability standard found at § 718.204(b)(2)(iii) is inapplicable to this case because the Claimant did not present evidence of cor pulmonale with right-sided congestive heart failure.

Where total disability cannot be established under subparagraphs (b)(2)(i), (ii), or (iii), § 718.204(b)(2)(iv) provides that total disability nevertheless may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.* A physician's opinion need not be phrased in the words of "total disability" provided the assessment elaborates on Claimant's impairment in such a way to allow the inference of total disability. *Bueno v. Director, OWCP*, 7 B.L.R. 2-337 (1984). A medical report which describes the severity of the impairment or the physical effect imposed by the respiratory or pulmonary impairment may be sufficient to establish total disability in conjunction with the exertional requirements of Claimant's usual coal mine employment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-104 (1986).

Dr. Guicheteau did not provide an opinion regarding total disability. Drs. Repsher, Tuteur, Dahhan, Renn, and Fino opined that Mr. Olson is totally disabled, although Drs. Tuteur,

Dahhan, and Renn did not attribute it to a respiratory condition. Drs. Pueringer, Repsher, and Fino asserted that the miner's total disability was due to his idiopathic pulmonary fibrosis.

I place great weight on the opinions of Drs. Pueringer, Repsher, and Fino because of Mr. Olson's clinical presentation, progressive difficulty breathing, and final blood gas study. For the same reasons, I find the conclusions of Drs. Tuteur, Dahhan, and Renn less probative. Furthermore, the finding of total disability is consistent with Mr. and Mrs. Olson's testimony about the miner's current condition. Therefore, I find that the medical opinion evidence supports a finding of total disability.

In considering all the evidence, both like and unlike, under § 718.204(b)(2), I find the medical opinion evidence, as supported by the most recent blood gas study, to be the most persuasive evidence. Accordingly, I conclude that Mr. Olson has established that he is totally disabled.

#### Due to Pneumoconiosis

Finally, Claimant must establish that his disability arose out of coal mine employment. The Ninth Circuit has not specifically announced the standard it requires to establish total disability causation. Thus, I rely upon the language of § 718.204(c)(1), which states that:

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in Sec. 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

In this case, none of the physicians attributed Mr. Olson's total disability to pneumoconiosis. I credit these opinions for all of the reasons stated above. Consequently, I find that the Claimant has failed to establish total disability causation. Therefore, benefits must be denied.

#### Entitlement:

As Claimant has failed to establish that he has coal workers' pneumoconiosis and that he is totally disabled due to pneumoconiosis, I find that he is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any attorney's fee to Claimant for legal services rendered in pursuit of benefits.

**ORDER**

It is therefore ORDERED that the claim of Dale A. Olson for benefits under the Act is DENIED.

A

DONALD B. JARVIS  
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, D.C. 20210.**